State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	The Charlotte Hungerford Hospital	
Doing Business As		
Name of Parent Corporation		
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	540 Litchfield Street Torrington, CT 06790	
Applicant type (e.g., profit/non-profit)		
Contact person, including title or position	John Capobianco, Vice President, Patient Care Services and Administration	
Contact person's street mailing address	540 Litchfield Street Torrington, CT 06790	
Contact person's phone #, fax # and e-mail address	Phone: 860-496-6611 Fax: 860-482-8627 Email: jcapobianco@hungerford.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Discontinue PET service at Winsted Site

b. Type of Proposal, please check all that apply:

✓ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ✓ Service Termination

☐ Bed Addition` ☐ Bed Reduction ☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost cost greater than $ 1,000,000

☐ Equipment Acquisition greater than $ 400,000

☐ New ☐ Replacement ☐ Major Medical

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):
100 Spencer Street, Winsted, CT 06098

d. List all the municipalities this project is intended to serve:
Winsted

e. Estimated starting date for the project: As soon as possible.

f. Type of project: 21 **(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$0.00**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$0.00**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☐ Funded Depreciation ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: The Charlotte Hungerford Hospital

Project Title: Discontinue PET service at Winsted Site

I, Daniel J. McIntyre, President and Executive Director
(Name) (Position – CEO or CFO)

of The Charlotte Hungerford Hospital being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that The Charlotte Hungerford Hospital complies with the
(Facility Name)

appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Daniel J. McIntyre 6/14/06
Signature Date

Subscribed and sworn to before me on 14th June 2006

Annamarie Corrado
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 4/30/2011

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

1. **Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.**

   Acute care hospital (please see the attached license).

2. **What types of services are being proposed and what DPH licensure categories will be sought, if applicable?**

   We propose to terminate a mobile PET service authorized under CON Docket # 06-30732-DTR. The service will be totally housed at the Hospital's main campus. There will be no decrease in the availability of service time.

3. **Who is the current population served and who is the target population to be served?**

   The target population remains the same. We found that the majority of our PET patients reside in the Torrington market (88%) with 12% coming directly from the Winsted market in calendar year 2004, the year the PET was available in Winsted. (Please see attached).

4. **Identify any unmet need and how this project will fulfill that need.**

   N/A

5. **Are there any similar existing service providers in the proposed geographic area?**

   Not at the present time.

6. **What is the effect of this project on the health care delivery system in the State of Connecticut?**

   None known.

7. **Who will be responsible for providing the service?**

   N/A

8. **Who are the payers of this service?**

   Payer mix is as follows:

Zip Code Analysis PET Scan

		Jan 1, 2004 - March 31, 2004		4/1/04 - 6/30/04	
		Total	% of Total	Total	% of Total
06094	Winchester Center	1	1%	0	0%
06098	Winsted	4	6%	10	14%
06790	Torrington	33	49%	24	34%
06791	Harwinton	9	13%	5	7%
	all other	21	31%	31	44%
	Total	68		70	

		7/1/04 - 9/30/04		10/1/04 - 12/31/04	
		Total	% of Total	Total	% of Total
06094	Winchester Center	2	3%	0	0%
06098	Winsted	6	9%	10	14%
06790	Torrington	20	29%	30	43%
06791	Harwinton	2	3%	2	3%
	all other		0%	27	39%
	Total	69		69	

		Calendar Year 2004	
		Total	% of Total
06094	Winchester Center	3	1%
06098	Winsted	30	11%
06790	Torrington	107	39%
06791	Harwinton	18	7%
	all other	79	29%
	Total	276	

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0042

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

The Charlotte Hungerford Hospital of Torrington, CT, d/b/a The Charlotte Hungerford Hospital is hereby licensed to maintain and operate a General Hospital.

The Charlotte Hungerford Hospital is located at 540 Litchfield Street, Torrington, CT 06790

The maximum number of beds shall not exceed at any time:

13 Bassinets
109 General Hospital beds

This license expires **September 30, 2007** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2005. RENEWAL.

Satellites

The Charlotte Hungerford Hospital Cancer Center, 200 Kennedy Drive, Torrington, CT
The Charlotte Hungerford Northwest Connecticut Medical Walk In, East Main Street, Torrington, CT
Winsted Health Center, 115 Spencer Street, Winsted, CT
The Charlotte Hungerford Psychiatric Outpatient Clinic-Peck Road, 294 Main Street, Winsted, CT

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner